WEST VIRGINIA Health Right INC.
CommUNITY Wellness Center

Adult Information Form

Name_____ Gender M/F/NS (circle)

Date of Birth: _____ Phone: Cell: _____ Other: _____

Address: _____

Race: Check all that apply

- Caucasian
- African American
- Asian
- Am. Indian/Alaskan
- Hawaiian/Pacific Islander
- Other

Emergency Contact Information

Name: _____Phone: Cell: _____

List any food or drug allergies: _____
Other Medical Issues: _____
_____

Have you been Vaccinated? Y/N Do you have a regular doctor? Y/N

Primary Care Provider_____ Medicare/Medicaid? Y/N

Do you need help with any additional services? Check any that apply.

- **Behavioral Health**
- **Housing**
- **Substance Use**
- **Food**
- **Medical Services**
- **Covid-19 Vaccine**
- **Education**
- **Job Training**
- **Employment**
- **Clothing**

Patient Agreement/Disclosure: I agree to allow WV Health Right to complete any patient assistance program enrollment process on my behalf which may include disclosure of personal and medical information and other information necessary to determine eligibility for available programs. Your information is confidential and secure and only available to WV Health Right's administrative staff.

Signature: _____ Date: _____

For Clinic Use Only

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